MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

PATIENT TREATMENT PLAN

Effective Date: November 7, 2003 **Policy #:** TX-12

I. PURPOSE: To establish procedures for the development, implementation, and review of patient treatment plans.

II. POLICY: Each patient will have an individualized treatment plan that meets standards set in state statutes (53-21-162, M.C.A.) and professional guidelines as part of their medical record.

III. DEFINITIONS:

A. Treatment Plan - A written plan that identifies the patient's treatment needs, the goals and objectives for treatment, and the interventions and strategies to be used by staff in helping the patient to attain goals and objectives. The plan will provide a concise, thorough outline of the patient's clinical course at Montana State Hospital. It will identify how the efforts of the multi-disciplinary treatment team responsible for providing services to the patient are to be coordinated in order to meet stated treatment goals and objectives.

B. Integrated Summary - A summary that consolidates the clinical information gathered from the assessments into a single note.

C. Treatment Goal - A broad statement of desirable behavior change that a patient should achieve to reflect maximum or optimal treatment outcome. A goal is a long-range projection.

D. Treatment Objective - A statement of what the patient must do. Objectives are written in behavioral terms that specify observable and measurable indices of progress used to measure incremental progress toward individualized treatment goals. An objective is a short-range projection.

E. Practitioner – Attending practitioner or advanced practice registered nurse with a clinical specialty in psychiatric mental health nursing.

F. Certified Mental Health Professional (CMHP) - A person who has been certified by the Department of Public Health and Human Service according to Montana Code 53-21-106.

IV. RESPONSIBILITIES:

A. All employees are responsible for abiding by this policy.

B. Supervisors are responsible for communicating the content of this policy and enforcing it.

C. Staff Development is responsible for orientating all new employees on this policy.

V. PROCEDURES:

A. Each patient admitted to Montana State Hospital must have a comprehensive mental examination and review of behavioral status within twenty-four (24) hours and physical examination within forty-eight (48) hours after admission. As part of these procedures, a preliminary treatment plan will be developed by a practitioner and other professional staff to provide intervention strategies early in the course of hospitalization. The preliminary plan may be modified, but will be used as a guide for treatment and intervention strategies to be used until a comprehensive treatment plan is developed within ten (10) days after the patient's admission.

B. Each patient must have an individualized treatment plan. This plan must be developed by appropriate professional persons, including a practitioner, nurse, social worker, and rehabilitation professional and must be implemented no later than ten (10) days after the patient's admission (53-21-162[2] M.C.A.).

C. The treatment plan is to be based on the results of a comprehensive, multi-disciplinary assessment that evaluates the patient's physical, emotional, psychological, medical, behavioral, social, and recreational needs. When appropriate, other needs including legal, vocational, religious, and nutritional needs must also be assessed and addressed in the treatment plan.

D. The treatment plan must reflect any identified acute or chronic medical problems for which the patient is receiving treatment.

E. A multi-disciplinary team meeting will be held to discuss the discipline specific assessments and to prioritize the identified needs into a comprehensive treatment plan. An Integrated Summary note must be entered in the chart reflecting the results of this meting. This process of review with subsequent integrated summary note must be made when the treatment plan is developed following admission to the hospital or transfer between units. The treatment plan must indicate the persons present at this meeting. The actual writing of the treatment plan may either occur at this time or be completed soon after by an appropriate

professional person who was present at the meeting. The integrated summary note must follow the hospital-approved format.

F. If assessment procedures identify a problem or a need for treatment that will not be provided while the patient is at Montana State Hospital, a justification must be documented in the clinical record. When deferred problems are medical in nature, the progress notes confirm that the decision to postpone was made directly by or in consultation with a practitioner. If there are problems the patient may need to receive treatment for at some later date but can be addressed in the community after discharge, they will be addressed in the aftercare plan.

G. Each patient has the right to ongoing participation, in a manner appropriate to the patient's capabilities, in the planning of mental health services to be provided. A patient also has the right to a reasonable explanation of the following, in terms and language appropriate to the patient's condition and ability to understand:

1. The patient's general mental and physical condition;
2. The objectives of treatment;
3. The nature and significant possible adverse effects of recommended treatments;
4. The reasons why a particular treatment is considered appropriate;
5. The reasons why access to certain visitors may not be appropriate; and
6. Any appropriate and available alternative treatments, services, or providers of mental health services.

A patient is not to receive treatment established pursuant to the treatment plan in the absence of the patient's informed, voluntary, and written consent to treatment, except treatment during an emergency if the treatment is pursuant to or documented contemporaneously by the written order of a responsible mental health professional; or permitted under the applicable law in the case of a person committed to a facility by a court (53-21-162[5]).

A description of the patient's involvement in the treatment planning process shall be documented in the clinical record. This note should include a description of how the patient contributed to the development of his/her treatment plan, the patient's level of understanding of his/her treatment plan and the patient's level of commitment to making the plan successful. Indication of the patient's consent to treatment will be in accordance with the hospital's policy on Informed Consent for Treatment. For those patients who lack the capacity to give informed consent to treatment, a guardian will be appointed in accordance with statutory procedures and hospital policy. Staff must then involve the guardian in the treatment planning process and document that involvement in the progress notes.

H. With the patient's consent, family members or significant others will be encouraged to be involved in the treatment planning process. This involvement must be documented in the record.

I. Each treatment plan must contain:

1. One or more statements describing the nature of the specific problems, needs, and functional strengths and limitations of the patient;
2. A statement of the least restrictive treatment conditions necessary to achieve the purposes of hospitalization;
3. A statement of the treatment goals and specific behavioral objectives, with a projected timetable for their attainment;
4. A statement and rationale for the plan of treatment for achieving the treatment goals and objectives;
5. A specification of staff responsibility for attaining each treatment goal;
6. Criteria for a reduction in restrictions within the hospital setting (e.g., open ward, increased campus pass);
7. A notation of any therapeutic tasks and labor to be performed by the patient; and
8. The specific treatment modalities/interventions to be used, including frequency and responsible individual or discipline.

J. Treatment services provided by outside providers (e.g, physical therapy, speech therapy) will be identified on the treatment plan.

K. Overall development, implementation, and supervision of the treatment plan are the responsibility of the patient's assigned practitioner. The practitioner may delegate responsibility for ensuring that the treatment plan is accurate, up-to-date, and reviewed regularly to a certified mental health professional. This assignment must be indicated on the treatment plan.

L. The multi-disciplinary treatment team assigned to provide primary services to the patient will periodically reevaluate the patient and revise the individualized treatment plan based on changes in the patient's condition. The plan may under go review at any time, but must be reviewed in accordance with the following:

1. Whenever a patient is transferred from one treatment program to another, the program receiving the patient shall complete a reassessment of the patient's treatment needs and establish a revised treatment plan within ten (10) days of the transfer.
2. Prior to a patient's discharge, their treatment plan shall be reviewed in order to identify the degree to which treatment goals and objectives have been attained and information that needs to be passed on to aftercare service providers.

3. Whenever there is a major change in the patient's condition the treatment plan must be reviewed and updated. Examples of major changes may include escape form hospital, behavioral crises, physical illness and repeated use of seclusion and restraint.
4. The treatment plan is to be reviewed at the conclusion of the initial estimated length of stay and subsequent estimated lengths of stay indicated in the patient's discharge plan.
5. The plan must be reviewed at intervals of no less than monthly for the first ninety (90) days and every ninety (90) days thereafter.

At each review of the treatment plan, a professional person (CMHP or practitioner) who is not primarily responsible for the patient's treatment plan must participate in the review process. The results of the review must be documented in the progress notes with changes entered on the treatment plan as indicated. Each treatment plan review note must indicate team members involved in the review and includes at a minimum a practitioner, nurse, social worker, and the patient and/or guardian.

M. Staff members will use a treatment plan and treatment plan review format that has been approved by the hospital administration. Treatment plans may be developed using personal computers as long as the prescribed hospital format is used. The official plan is the hard copy entered into the patient's clinical record.

N. The treatment plan is a legal document and is part of the patient's permanent medical record. All entries are to be made in black ink. They may be either handwritten or typed. Errors must not be erased or obliterated. Errors are to be marked in accordance with the Charting – Rules to Observe Policy.

O. The treatment plan will be kept in the patient's chart in a location where it is readily accessible to anyone needing to review the plan contents. When the plan contains multiple pages, each page will be individually accessible.

P. The treatment plan is to be used as a guide for the regular completion of progress notes. Progress notes need to contain information indicating the extent to which treatment interventions are implemented and whether the patient is making progress toward meeting the stated goals and objectives.

Q. At the time the treatment plan is initially formulated, staff will offer to provide patients with a copy of their treatment plan. Staff will furnish copies of the treatment plan when it is requested by patients at any reasonable time during the course of hospitalization. Treatment plans will also be provided to guardians upon request.

R. In-service training programs will be provided to help staff understand proper procedures for the development, implementation, and review of patient treatment plans.

S. The development, implementation, and review of patient treatment plans will be reviewed regularly through hospital quality improvement procedures.

VI. REFERENCES: Hospital Licensure Standards, Montana Statutes (53-21-162, M.C.A.)

VII. COLLABORATED WITH: Director of Quality Improvement and Public Relations, Director of Information Resources, Social Work Chief, Psychology Chief, and Team Leaders

VIII. RESCISSIONS: #TX-12, *Patient Treatment Plan* dated February 14, 2000; HOPP #: 13-01T.112680, *Patient Treatment Plan* dated May 1976.

IX. DISTRIBUTION: All Hospital Policy Manuals, all CMHP's and all practitioners.

X. REVIEW AND REISSUE DATE: November 2006

XI. FOLLOW-UP RESPONSIBILITY: Director of Nursing Services

XII. ATTACHMENTS:

Attachment A - Treatment Plan Review Note
Attachment B - Integrated Summary
Attachment C - Treatment Plan

_____/___/__		_____/___/__	
Ed Amberg	Date	Thomas Gray, MD	Date
Hospital Administrator		Medical Director	